MEDI-CAL UPDATE

Allied Health
Bulletin 335

Billing and Policy
Orthotics and Prosthetics Bulletin 335

September 2003

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPAA: Provider Manual Updates

The September 2003 Health Insurance Portability and Accountability Act (HIPAA) implementation resulted in the following changes in the Medi-Cal provider manuals. All changes are effective for dates of service on or after September 22, 2003.

Important: When you follow the remove and replace instructions in this bulletin and update your manual, please retain the pages you remove. Place them after the *Appendix* tab at the back of your manual. These pages will help you bill for services that you rendered prior to September 22, 2003.

New HIPAA In Review

A handy *HIPAA In Review* guide has been included in this bulletin for you to insert in your provider manual at the end of the *HCFA 1500 Completion* section. This guide summarizes important *HCFA-1500*-related changes that resulted from the September 2003 phase of HIPAA implementation.

Place of Service Codes

Place of Service Field (Box 24B)

24	A					B
DATE(S) OF SERVICE						Place of Service
FROM			TO			
MM	DD	YY	MM	DD	YY	
						XX

Local Medi-Cal Place of Service codes are being replaced with national Place of Service codes, which are entered in the same box (24B) as previously entered.

Place of Service codes are defined by the Centers for Medicare and Medicaid Services (CMS).

Manual Changes

- Medi-Cal Place of Service code values are changed to national Place of Service code values.
- A *Code Correlation Guide* showing the relationship between Medi-Cal Place of Service and national Place of Service codes is added at the end of the *HCFA 1500 Completion* section to help you understand how local Place of Service codes are being converted to national Place of Service codes.

Please see **HIPAA**, *page 2*

HIPAA *(continued)*

Billing Limit Exception to Delay Reason Codes

COB Field (Box 24J)

I	J	K
EMG	COB	RESERVED FOR LOCAL USE
	XX	

Local Medi-Cal billing limit exception codes are being replaced with national delay reason codes. Delay reason codes are entered in Box 24J, the same box where billing limit exception codes were entered.

Use of national delay reason codes is mandated by HIPAA.

Manual Changes

- A *Code Correlation Guide* showing the relationship between billing limit exception and delay reason codes is added at the end of the *HCFA 1500 Completion* section to help you understand how Medi-Cal billing limit exception codes have been converted to national delay reason codes.

Modifiers

Procedures, Services or Supplies Field (Box 24D)

D		E
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE
X X X X X 2 6	**4 7 6 0 6 2**	

Up to four modifiers may be entered on HCFA 1500 claims. All modifiers (-26, -47, -60 and -62 in the preceding example) must be billed immediately following the procedure code, with no spaces, in the Procedures, Services or Supplies/Modifier field (Box 24D).

Manual Changes

- The *HCFA 1500 Completion* section is updated to include instructions for billing with up to four modifiers.
- When billing for services rendered to recipients who are patients in subacute care facilities, you must enter the Place of Service code "99" in the *Place of Service* field (Box 24B) and modifier -HA (pediatric) or -HB (adult) in the last-used modifier field.

"From-Through" Billing

Date(s) of Service Field (Box 24A)

24 A						B
DATE(S) OF SERVICE						Place of Service
FROM			TO			
MM	DD	YY	MM	DD	YY	
0 9 2 2 0 3			0 9 3 0 0 3			

"From-through" services with a "from" date of service on or after September 22, 2003 are billed with national codes. "From-through" services with a "from" date prior to September 22, 2003 are billed with local Medi-Cal codes. (Please note, the "through" date is "to" on the HCFA 1500.)

Please see **HIPAA**, *page 3*

HIPAA *(continued)*

Guidelines

HIPAA changes for the September 2003 phase of HIPAA implementation established the following guidelines:

- Claims with dates of service on or after September 22, 2003 must be submitted with national Place of Service and delay reason codes.
- Claims for services prior to September 22, 2003 must be billed with local Medi-Cal Place of Service and billing limit exception codes.
- Claims for services rendered on dates of service that include both pre- and post-September 22, 2003 dates must be billed on separate claims (split billed) with national codes on one claim and local Medi-Cal codes on another.

"From-Through" Exemption

Claims for services that require "from-through" billing (identified in policy sections) do not require the split billing. They are billed as indicated in the italicized text under the preceding diagram.

Manual Changes

- The *HCFA 1500 Special Billing Instructions* section is updated to include the preceding "from-through" information.

2003 CPT-4 and HCPCS Updates: Implementation September 22, 2003

The 2003 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II and local Level III codes are effective for Medi-Cal for dates of service on or after September 22, 2003. Some of the policy changes are highlighted as follows.

DURABLE MEDICAL EQUIPMENT

TAR Requirement: HCPCS Code E0442, E0434 and E0435

Claims for liquid oxygen codes E0434 (portable liquid oxygen system, rental), E0435 (portable liquid oxygen system, purchase) and E0442 (oxygen contents, liquid) require prior authorization. A *Treatment Authorization Request* (TAR) is required for code E0442 when more than 50 pounds are needed by a patient during a calendar month. *The updated information is reflected on manual replacement page dura cd 7 (Part 2).*

Taxable Codes

The following new DME codes are taxable: A4606, A4632, E0445, E0483, E0484, E0618, E0619 and E0636. *The updated information is reflected on manual replacement page tax 7 (Part 2).*

Supplies: Billing for Replacement Parts

New HCPCS supply codes A4606, A4632, A7030 – A7039 and A7044 are for replacement parts for specific equipment. These codes must be billed with purchase modifiers -Y2 or -Y7, depending on their taxable status. Because reimbursement for the rental of equipment includes all necessary supplies and accessories, these items may not be billed in conjunction with the rental of their specific equipment. Claims for these codes must include documentation in the *Reserved For Local Use* field (Box 19) that the equipment is patient-owned. Additionally, claims for A4632 must include the type of battery provided. *The updated information is reflected on manual replacement pages dura cd 7 (Part 2) and tax 7 (Part 2).*

Please see **CPT-4/HCPCS***, page 4*

CPT-4/HCPCS *(continued)*

HCPCS Code E0483

HCPCS code E0483 (air-pulse generator system) replaces local codes X3206 and X3212. All medical policies for X3206 and X3212 are applicable to E0483. Reimbursement for E0483 is for rental only and must be billed with modifier -Y6 (rental with sales tax). The rental reimbursement rate for E0483 includes an amount that allows for the replacement of the vest every two years at no additional cost to the Medi-Cal program. New code A7025 (replacement vest) is not a Medi-Cal benefit. *The updated information is reflected on manual replacement pages dura cd 9 (Part 2) and tax 7 (Part 2).*

ORTHOTICS AND PROSTHETICS

Deleted and Replacement Codes

HCPCS codes L5660, L5662, L5663 and L5664 are replaced by K0556 – K0559. *The updated information is reflected on manual replacement page ortho cd2 5 (Part 2).*

Reimbursement Restrictions for New HCPCS Codes

The following HCPCS codes have Medi-Cal reimbursement restrictions:

- K0556 – K0559 are limited to twice within a six-month period
- L5781, L5782, L5848, L5995, L6025, L6638, L6646, L6647, L6648, L7367 and L7368 are limited to once within a 12-month period
- L0450 – L0490, L1652, L1836, L1901, L3651, L3652, L3701, L3762, L3909, L3911, L4386 and S1040 are limited to twice in a 12-month period
- L1836 and L1901 are reimbursable to podiatrists

HCPCS Code S1040

New HCPCS code S1040 (cranial molded helmet) is a new Medi-Cal benefit, subject to prior authorization, with the following restrictions:

- Maximum age: 2 years of age
- Frequency limit: Two in 12 months
- Diagnosis restrictions: 754.0 (plagiocephaly) and 756.0 (craniosynostosis)
- Requires a TAR, which must include the name and address of the FDA-approved lab that makes the helmet

The updated information is reflected on manual replacement page ortho 8 (Part 2).

Elimination of Benefits: Foot Inserts, Arch Supports and Elastic Stockings

Effective for dates of service on or after October 1, 2003, the following HCPCS codes will no longer be reimbursable by Medi-Cal:

- Foot Inserts: HCPCS codes L3000 – L3030
- Arch Supports: HCPCS codes L3040 – L3090, L3170
- Elastic Stockings: HCPCS codes L8100 – L8180, L8220, L8239

Please see **CPT-4/HCPCS***, page 5*

CPT-4/HCPCS *(continued)*

Treatment Authorization Requests: Requirements and Thresholds

Effective for dates of service on or after October 1, 2003, TARs will be required for the following appliances. A signed prescription from a physician, podiatrist or dentist must accompany all TARs for orthotic and prosthetic appliances.

- Orthotic appliances when the cumulative total of purchase, replacement or repairs exceeds $250 per 90-day period
- Prosthetic appliances when the cumulative total of purchase, replacement or repairs exceeds $500 per 90-day period
- Any unlisted, "By Report," or "By Invoice" appliance

Providers requesting prior authorization of bilateral appliances (-LT [left] and -RT [right]) should request the procedure for the separate sides on two lines of the TAR. Do not use any other modifiers on the TAR.

Provider Restrictions

Effective for dates of service on or after October 1, 2003, only physicians and certified orthotists and prosthetists may be reimbursed for orthotic and prosthetic appliances. In addition to physicians, certified orthotists and certified prosthetists, codes with double asterisks (**) are reimbursable to pharmacists who successfully completed the National Community Pharmacists Association (NCPA) program of Health Supports and Appliances Certification.

Clinical Nurse Specialist: Billing Medicare Part B Crossover Claims

Effective immediately, Medi-Cal reimburses Clinical Nurse Specialists (CNS) for Medicare-approved Part B crossover services. The majority of CNS crossover claims automatically cross over to Medi-Cal from Medicare. Claims that do not cross over must be hard copy billed on the *HCFA 1500* claim form. To qualify for enrollment as a Medi-Cal crossover provider, a CNS must be enrolled in the Medicare Program and billing as a freestanding CNS provider, be a registered nurse licensed to practice in the State of California and possess Board of Registered Nursing (BRN) certification as a CNS. These Medi-Cal payments are for crossovers only and are not available for straight Medi-Cal. To receive an application to become a CNS crossover-only Medi-Cal provider, call the Provider Support Center (PSC) at 1-800-541-5555.

A CNS can bill and receive direct reimbursement for services covered by Medi-Cal for services paid by Medicare, which include the following primary care physician services as examples:

Evaluation and Management (CPT-4 Codes)

99201 – 99215, 99221, 99222, 99231, 99232, 99281 – 99284, 99301 – 99313, 99321, 99322, 99331, 99332, 99341, 99342, 99347 – 99349, 99381 – 99384, 99391 – 99394 and 99429 – 99433.

General Medicine (CPT-4 Codes)

90749, 90799, 91105, 92551, 92552, 92950, 93005, 94650 – 94668, 95004, 95009, 95010, 95115, 96450 and 97010 – 97039.

Please see **Clinical Nurse**, *page 6*

Clinical Nurse *(continued)*

Pathology (includes immunology and hematology) (CPT-4 Codes)

81000 – 81005, 81015, 81025, 81050, 82270, 82273, 82705, 85007 – 85023, 85025 – 85044, 85048, 85170, 85345, 85610, 85651 – 85660, 86490 – 86585, 87040 – 87070, 87081, 87088, 87164, 87177, 87205, 87206, 87210, 87220, 88150, 89050, 89125 and 89130.

Surgery (includes obstetrics, gynecology and maternal care services) (CPT-4 Codes)

10040, 10060, 10080, 10120, 10140, 10160, 11100 – 11402, 11420 – 11422, 11440 – 11442, 11720, 11721, 11730, 11732 – 11750, 11975 – 11977, 12001 – 12004, 12011, 12031, 12032, 12041, 12042, 12051, 16000, 16020, 17000, 17003, 17106, 17107, 17110, 17250, 26010, 29049, 29075, 29085, 29105, 29125, 29405, 29440, 29515, 29580, 29700, 29730, 29740, 30300, 30901, 31500, 36000, 38220, 38221, 38230, 46600, 53670, 57150, 57160, 57170, 57452, 57500, 57511, 58300, 58301, 59050, 59300, 59400, 59410, 59610, 59612, 62270, 65205, 69200 and 69210.

Obstetric and Maternal Care Services (HCPCS Codes)

Z1032, Z1034, Z1038 and Z6200 – Z6500.

Special Services

CPT-4 code 99070, HCPCS codes Z5218 and Z5220.

Subacute Care (HCPCS Codes)

X9936, X9938, X9940, X9942 and X9944.

Injection (HCPCS Codes)

X5300 – X7600.

The updated information is reflected on manual replacement pages medi cr hcfa 3 and 4 (Part 2).

Instructions for Manual Replacement Pages
Orthotics and Prosthetics (OAP) Bulletin 335 September 2003

Part 2

Remove and replace:	cif co 1/2 *****
Remove:	dura cd 1 thru 16
Insert:	dura cd 1 thru 17 *(new)*
Remove and replace:	hcfa comp 1/2, 15 thru 22
Insert at end of the *HCFA 1500 Completion* section:	*HIPAA In Review (new)* *Code Correlation Guide (new)*

Notice: The September 2003 Orthotics and Prosthetics *Medi-Cal Update #335* is being mailed to you in two parts (in separate envelopes) this month. Please watch for this second mailing containing additional pages and update your manual.

* Pages updated/corrected due to ongoing provider manual revisions.

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The September 2003 Orthotics and Prosthetics *Medi-Cal Update* #335 was mailed to you in two parts (in separate envelopes) this month. The first mailing was sent to you earlier this month and contained all the September bulletin articles, as well as a portion of the manual replacement pages.

This second mailing contains the remaining manual replacement pages.

Part 2

Remove:	hcfa spec 1 thru 7
Insert:	hcfa spec 1 thru 9 *(new)*
Remove and replace:	hcfa sub 1 thru 5
Remove:	hcfa tips 1 thru 3
Insert:	hcfa tips 1 thru 4 *(new)*
Remove and replace:	hcpcs iii 1 thru 4 *
	medi cr hcfa 3/4
	medi non hcp 1/2
	modif app 1 thru 4
Remove:	ortho 1 thru 13
Insert:	ortho 1 thru 10
Remove:	ortho cd1 1 thru 27
Insert:	ortho cd1 1 thru 26
Remove:	ortho cd2 1 thru 25
Insert:	ortho cd2 1 thru 22
Remove:	ortho ex 1 thru 5
Insert:	ortho ex 1 thru 7 *(new)*
Remove and replace:	spe dev 5/6
	tar comp 9 thru 12 *
	tax 3 thru 8

* Pages updated/corrected due to ongoing provider manual revisions.